

## CHILD/ADOLESCENT BIOPSYCHOSOCIAL ASSESSMENT

### Demographics

<b>Client Name:</b>	<b>Date:</b>
<b>Current Address:</b> Street City/State Zip Code	<b>Phone #:</b> (     )     -
<b>Date of Birth:</b>	<b>Marital/Relationship Status:</b>
<b>Nation/Tribe/Ethnicity:</b>	
<b>Primary language of client:</b>	<b>Secondary:</b>
<b>Referral Source:</b>	<b>Phone:</b>
<b>Emergency Contact:</b>	<b>Phone:</b>

### Family Relationships

Does the client have any children?						
Name	Age	Date of Birth	Sex	Custody? Y/N	Lives With?	Additional Information

  

Who else lives with the client? (Include spouses, partners, siblings, parents, other relatives, friends)				
Name	Age	Sex	Relationship	Additional Information

<b>Primary language of household/family:</b>	<b>Secondary:</b>
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### Family History

Family History of (select all that apply):						
	Mother	Father	Siblings	Aunt	Uncle	Grandparents
Alcohol/Substance Abuse						
History of Completed Suicide						
History of Mental Illness/Problems such as:						
Depression						
Schizophrenia						
Bipolar Disorder						
Alzheimer's						
Anxiety						
Attention Deficit/Hyperactivity						
Learning Disorders						
School Behavior Problems						
Incarceration						
Other						
<b>Comments:</b>						

## CHILD/ADOLESCENT BIOPSYCHOSOCIAL ASSESSMENT

**Critical Population (choose all that apply)**

Funding Source	Residential	Legal Involvement
<input type="checkbox"/> Food Stamp Recipient	<input type="checkbox"/> Homeless	<input type="checkbox"/> Protective Services (APS/CPS)
<input type="checkbox"/> TANF Recipient	<input type="checkbox"/> Shelter Resident	<input type="checkbox"/> Court Ordered Services
<input type="checkbox"/> SSI Recipient	<input type="checkbox"/> Long Term Care Eligibility	<input type="checkbox"/> On Probation
<input type="checkbox"/> SSDI Recipient	<input type="checkbox"/> Long Term Care Resident	<input type="checkbox"/> On Parole
<input type="checkbox"/> SSA (retirement) Recipient		<input type="checkbox"/> On Pre-Release
<input type="checkbox"/> Other Retirement Income	<b>Disability</b>	<input type="checkbox"/> Mandatory Monitoring
<input type="checkbox"/> Medicaid Recipient	<input type="checkbox"/> Physical Disability	
<input type="checkbox"/> Medicare Recipient	<input type="checkbox"/> Severely Mentally Ill	<b>Other</b>
<input type="checkbox"/> General Assistance	<input type="checkbox"/> SED	<input type="checkbox"/> Currently pregnant
	<input type="checkbox"/> Developmentally Disabled	<input type="checkbox"/> Woman w/dependents
	<input type="checkbox"/> Chronically Mentally Ill	
	<input type="checkbox"/> Regional Behavioral Health Authority	
<b>Contact Information</b> <b>(Secure consents for agency contacts, when possible)</b>		
<b>Name of Caseworker</b>	<b>Agency</b>	<b>Phone number</b>

**Client's/Family's Presentation of the Problem:**

**Client's/Family's Expected Outcome:**

### Physical functioning

**Allergies (Medication & Other):**

**Current Medical Conditions:**

**Current Medications (include herbs, vitamins, & over-the-counter):**

**Past Medications:**

**Past Medical History including hospitalizations/residential treatment (list all prior inpatient or outpatient treatment including RTC, group home, therapeutic foster care, aftercare, inpatient psychiatric, outpatient counseling):**

Dates	Inpt/Outpt	Location	Reason	Completed? Y/N

**Surgeries:**

## CHILD/ADOLESCENT BIOPSYCHOSOCIAL ASSESSMENT

### Pain Questionnaire

**Pain Management:** Is the client in pain now? ☐ Yes ☐ No  
 If yes, ask client to rate the pain on a scale of 1-10 (with 10 being the severest) and enter score here

Is the client receiving care for the pain? ☐ Yes ☐ No  
 If no, would the client like a referral for pain management? ☐ Yes ☐ No

### Nutrition

<b>Nutritional Status:</b>		Current Weight	Current Height	BMI
<b>Appetite:</b>		<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor, please explain below
<input type="checkbox"/> Recently gained/lost significant weight		<input type="checkbox"/> Binges/overeats to excess		
<input type="checkbox"/> Restricts food/Vomits/over-exercises to avoid weight gain		<input type="checkbox"/> Special dietary needs		
<input type="checkbox"/> Hiding/hording food		<input type="checkbox"/> Food allergies		
<b>Comments</b>				

### Child/Adolescent Growth & Development

<b>During pregnancy, did the biological mother have any of the following (select all that apply)?</b>			
<input type="checkbox"/> Amniocentesis	<input type="checkbox"/> Anemia	<input type="checkbox"/> Diabetes Mellitus	
<input type="checkbox"/> Emotional Problems	<input type="checkbox"/> Excessive weight gain	<input type="checkbox"/> German Measles	
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> High fever	<input type="checkbox"/> Kidney problems	
<input type="checkbox"/> No prenatal care	<input type="checkbox"/> Placenta Previa	<input type="checkbox"/> Premature labor	
<input type="checkbox"/> Vaginal bleeding	<input type="checkbox"/> Vaginal infection	<input type="checkbox"/> Other infection	
<input type="checkbox"/> Unknown	<input type="checkbox"/> Other:		
<b>During pregnancy, did the mother use any of the following (select all that apply)?</b>			
<input type="checkbox"/> Tobacco	<input type="checkbox"/> Alcohol	<input type="checkbox"/> Street Drugs	<input type="checkbox"/> Unknown
<b>Comments</b> (frequency and intensity of use, participation in treatment, birth defects or malformations due to drug/alcohol use among siblings):			
<b>Any problems with labor &amp;/or delivery?</b>		<b>Apgar Scores?</b>	
<b>Did the baby have any of the following after delivery (select all that apply)?</b>			
<input type="checkbox"/> Anemia	<input type="checkbox"/> Apnea	<input type="checkbox"/> Birth defects	<input type="checkbox"/> Blood transfusions
<input type="checkbox"/> Bradycardia	<input type="checkbox"/> Cord around neck	<input type="checkbox"/> Eye problems	<input type="checkbox"/> Fever/low temperature
<input type="checkbox"/> Hernia	<input type="checkbox"/> Hydrocephalus	<input type="checkbox"/> Infection	<input type="checkbox"/> Intensive Care
<input type="checkbox"/> Intracranial bleed	<input type="checkbox"/> Jitteriness	<input type="checkbox"/> Physical injury	<input type="checkbox"/> Seizures
<input type="checkbox"/> Surfactant	<input type="checkbox"/> Trouble breathing	<input type="checkbox"/> Trouble sucking	<input type="checkbox"/> 1 of multiples (twin, etc)
<input type="checkbox"/> Use of Oxygen	<input type="checkbox"/> Ventilator	<input type="checkbox"/> Yellow Jaundice	<input type="checkbox"/> Other:
<b>Developmental Milestones – please select any that the client did late or is still having trouble with:</b>			
<input type="checkbox"/> Rolling Over (2-6 months)	<input type="checkbox"/> Sitting (6-12 months)	<input type="checkbox"/> Standing (8-16 months)	
<input type="checkbox"/> Walking (8-16 months)	<input type="checkbox"/> Engaging peers (24-36 months)	<input type="checkbox"/> Toileting (24-36 months)	
<input type="checkbox"/> Dressing self (24-36 months)	<input type="checkbox"/> Feeding Self	<input type="checkbox"/> Sleeping alone	
<input type="checkbox"/> Tolerating separation	<input type="checkbox"/> Playing cooperatively	<input type="checkbox"/> Speaking	
<b>Are immunizations up to date?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			

## CHILD/ADOLESCENT BIOPSYCHOSOCIAL ASSESSMENT

<b>Has the client had any of the following (select all that apply)?</b>			
<b>Blood Disorders:</b> <input type="checkbox"/> Anemia <input type="checkbox"/> Bleeding <input type="checkbox"/> Bruising			
<b>Brain Disorders:</b> <input type="checkbox"/> Confusion <input type="checkbox"/> Headaches <input type="checkbox"/> Coordination Problems <input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Staring <input type="checkbox"/> Tremors <input type="checkbox"/> Tics (motor/vocal) <input type="checkbox"/> Head Injuries <input type="checkbox"/> Seizures			
<b>GI Problems:</b> <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Soiling <input type="checkbox"/> Vomiting			
<b>Heart/Lung Problems:</b> <input type="checkbox"/> Asthma <input type="checkbox"/> Chest Pain <input type="checkbox"/> Murmur <input type="checkbox"/> Surgery <input type="checkbox"/> Congenital Heart Disease			
<b>Hormone Problems:</b> <input type="checkbox"/> Obesity <input type="checkbox"/> Thyroid <input type="checkbox"/> Early Puberty <input type="checkbox"/> Late Puberty			
<b>Infections:</b> <input type="checkbox"/> Chicken Pox <input type="checkbox"/> Measles <input type="checkbox"/> Sinus infections			
<input type="checkbox"/> Ear infections <input type="checkbox"/> Meningitis <input type="checkbox"/> Whooping Cough <input type="checkbox"/> Encephalitis			
<input type="checkbox"/> Mumps <input type="checkbox"/> High fevers <input type="checkbox"/> Pneumonia <input type="checkbox"/> Other:			
<b>Injuries:</b> <input type="checkbox"/> Broken Bones <input type="checkbox"/> Stitches			
<b>Kidney Problems:</b> <input type="checkbox"/> Bed wetting <input type="checkbox"/> Daytime wetting <input type="checkbox"/> Infections			
<b>Muscle/Bone Problems:</b> <input type="checkbox"/> Scoliosis <input type="checkbox"/> Spasticity <input type="checkbox"/> Other:			
<b>Poisoning:</b> <input type="checkbox"/> Chemicals <input type="checkbox"/> Lead <input type="checkbox"/> Other:			
<b>Sensory Problems:</b> <input type="checkbox"/> Hearing <input type="checkbox"/> Tactile <input type="checkbox"/> Vision			
<b>Sexual Problems:</b> <input type="checkbox"/> Birth Control <input type="checkbox"/> Masturbation <input type="checkbox"/> Promiscuity			
<b>Skin Disorders:</b> <input type="checkbox"/> Acne <input type="checkbox"/> Birth Marks <input type="checkbox"/> Eczema <input type="checkbox"/> Hair Loss			

### Social

<b>Supportive Social Network?</b> (Rate the network using a scale of 1 Weak to 5 Strong)			
Immediate Family		Extended Family	
Friends		School	
Work		Community	
Religious		Other	
<b>What percentage of this network are substance-abusing?</b>			%
<b>Comment:</b>			
<b>Living Situation:</b>			
<input type="checkbox"/> Housing Adequate		<input type="checkbox"/> Housing Dangerous	
<input type="checkbox"/> Housing Overcrowded		<input type="checkbox"/> Homeless	
<input type="checkbox"/> Dependent Upon Others		<input type="checkbox"/> Incarcerated	
<input type="checkbox"/> Ward of State/Tribal Court			
<b>Additional Information:</b>			
<b>Employment: Currently Employed?</b>			
<input type="checkbox"/> Yes	<b>Employer</b>		<b>Length of Employment</b>
<input type="checkbox"/> Satisfied	<input type="checkbox"/> Dissatisfied	<input type="checkbox"/> Supervisor Conflict	<input type="checkbox"/> Co-worker Conflict
<input type="checkbox"/> No	<b>Last Employer:</b>		<b>Reason for Leaving:</b>
<input type="checkbox"/> Never Employed	<input type="checkbox"/> Disabled	<input type="checkbox"/> Student	<input type="checkbox"/> Unstable Work History
<b>Family Financial Situation:</b>			
<b>Presence or absence of financial difficulties: (Fields below are optional)</b>			
<input type="checkbox"/> No Current Problems		<input type="checkbox"/> Large Indebtedness	
<input type="checkbox"/> Relationship Conflicts Over Finances		<input type="checkbox"/> Financial Difficulties	
<input type="checkbox"/> Impulsive Spending		<input type="checkbox"/> Poverty or Below	
<b>Family's Source of Income (choose all that apply)</b>			
Employed: <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time <input type="checkbox"/> Seasonal <input type="checkbox"/> Temporary <input type="checkbox"/> Self-Employed		Unemployed: <input type="checkbox"/> Public Assistance <input type="checkbox"/> Actively seeking work <input type="checkbox"/> Not looking for work	
<input type="checkbox"/> Retirement <input type="checkbox"/> SSD		<input type="checkbox"/> SSDI <input type="checkbox"/> SSI	
<input type="checkbox"/> Medical Disability via Employer		<input type="checkbox"/> Other:	
<b>Sexual Orientation:</b>			
<input type="checkbox"/> Heterosexual		<input type="checkbox"/> Bisexual	
<input type="checkbox"/> Homosexual		<input type="checkbox"/> Transgendered	
<input type="checkbox"/> N/A at this time		Comment:	

## CHILD/ADOLESCENT BIOPSYCHOSOCIAL ASSESSMENT

### Family Social History

Describe family relationships & desire for involvement in the treatment process:

Perceived level of support for treatment? (scale 1-5 with 5 being the most supportive)

### Legal Status Screening

Past or current legal problems (select all that apply)?

<input type="checkbox"/> None	<input type="checkbox"/> Gangs	<input type="checkbox"/> DUI/DWI
<input type="checkbox"/> Arrests	<input type="checkbox"/> Conviction	<input type="checkbox"/> Detention
<input type="checkbox"/> Jail	<input type="checkbox"/> Probation	<input type="checkbox"/> Other

If yes to any of the above, please explain:

Any court-ordered treatment?	<input type="checkbox"/> Yes (explain below)	<input type="checkbox"/> No
Ordered by	Offense	Length of Time

### Child/Adolescent Educational Assessment

Current educational setting:

<input type="checkbox"/> Public	<input type="checkbox"/> Tribal	<input type="checkbox"/> Boarding (starting at age )	<input type="checkbox"/> Charter
<input type="checkbox"/> Private	<input type="checkbox"/> Home	<input type="checkbox"/> BIA	<input type="checkbox"/> Vocational
<input type="checkbox"/> Alternate	<input type="checkbox"/> GED	<input type="checkbox"/> College	<input type="checkbox"/> Other

Current grade level: ☐ Skipped a grade or ☐ been held back?

Any testing for an IEP (Individualized Education Plan)? ☐ Yes ☐ No

History of /or current placement in special education? How many hours per day?

For learning problems? ☐ Yes ☐ No For behavior problems? ☐ Yes ☐ No

History of hyperactivity at school? ☐ Yes ☐ No Comment:

Ever been expelled or suspended? ☐ Yes ☐ No Reason:

School attendance problems: ☐ Yes ☐ No Comments:

Other education-related concerns:

### Leisure & Recreation

Which of the following does the client do? (Select all that apply)

Spend Time with Friends	Sports/Exercise
Classes	Dancing
Time with Family	Hobbies
Work Part-Time	Watch Movies/TV
Go "Downtown"	Stay at Home
Listen to Music	Spend Time at Clubs/Bars
Go to Casinos	Other:

What limits the client's leisure/recreational activities?

## CHILD/ADOLESCENT BIOPSYCHOSOCIAL ASSESSMENT

### Functional Assessment

Is client able to care for him/herself? ☐ Yes ☐ No If No, please explain:

#### Living Situation:

☐ Housing Adequate ☐ Housing Dangerous ☐ Housing Overcrowded ☐ Homeless

☐ Dependent Upon Others ☐ Incarcerated ☐ Ward of State/Tribal Court

Additional Information:

#### Uses or Needs assistive or adaptive devices (select all that apply):

☐ None ☐ Glasses ☐ Walker ☐ Braille

☐ Hearing Aids ☐ Cane ☐ Crutches ☐ Wheelchair

☐ Translated Written Information ☐ Translator for Speaking ☐ Other:

### Psychological

**History of Depressed Mood:** ☐ Yes ☐ No

**History of irritability, anger or violence (tantrums, hurts others, cruel to animals, destroys property):**

**Sleep Pattern:** Number of hours per day \_\_\_\_\_ Time to onset of sleep? \_\_\_\_\_

☐ Normal ☐ Sleeping too much ☐ Sleeping too little

**Ability to Concentrate:** ☐ Normal ☐ Difficulty concentrating

**Energy Level:** ☐ Low ☐ Average/Normal ☐ High

**History of/Current symptoms of PTSD (re-experiencing, avoidance, increased arousal)? Select all that apply**

☐ Intrusive memories, thoughts, perceptions

☐ Nightmares

☐ Flashbacks

☐ Avoiding thoughts, feelings, conversations

☐ Numbing/detachment

☐ Restricted display of emotions

☐ Avoiding people, places, activities

☐ Poor sleep

☐ Irritability

☐ Hypervigilance

☐ Other:

**Any additional information:**

### Bereavement/Loss & Spiritual Awareness

**Please list significant losses, deaths, abandonments, traumatic incidents:**

#### Spiritual/Cultural Awareness & Practice

**Knowledgeable about traditions, spirituality, or religion?** ☐ Yes ☐ No Comment:

**Practices traditions, spirituality, or religion?** ☐ Yes ☐ No Comment:

**How does client describe his/her spirituality?**

**Does client see a traditional healer?** ☐ Yes ☐ No Comment:

## CHILD/ADOLESCENT BIOPSYCHOSOCIAL ASSESSMENT

### Abuse/Neglect/Exploitation Assessment

History of neglect (emotional, nutritional, medical, educational) or exploitation?  
If yes, please explain.

Has client been abused at any time in the past or present by family, significant others, or anyone else?) ☐ No ☐ Yes, explain:

Type of Abuse	By Whom	Client's Age(s)	Currently Occurring? Y/N
Verbal Putdowns			
Being threatened			
Made to feel afraid			
Pushed			
Shoved			
Slapped			
Kicked			
Strangled			
Hit			
Forced or coerced into sexual activity			
Other			

Was it reported? ☐ Yes ☐ No

To whom?

Outcome

Has client ever witnessed abuse or family violence? ☐ No ☐ Yes, explain:

# CHILD/ADOLESCENT BIOPSYCHOSOCIAL ASSESSMENT

## Behavioral Assessment

Abuse/Addiction – Chemical & Behavioral				
Drug	Age First Used	Age Heaviest Use	Recent Pattern of Use (frequency & Amount, etc)	Date Last Used
Alcohol				
Cannabis				
Cocaine				
Stimulants (crystal, speed, amphetamines, etc)				
Methamphetamine				
Inhalants (gas, paint, glue, etc)				
Hallucinogens (LSD, PCP, mushrooms, etc)				
Opioids (heroin, narcotics, methadone, etc)				
Sedative/Hypnotics (Valium, Phenobarb, etc)				
Designer Drugs/Other (herbal, Steroids, cough syrup, etc)				
Tobacco (smoke, chew)				
Caffeine				
<b>Ever injected Drugs?</b>		<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>If Yes, Which ones?</b>	
<b>Drug of Choice?</b>				
<b>Consequences as a Result of Drug/Alcohol Use (select all that apply)</b>				
<input type="checkbox"/> Hangovers	<input type="checkbox"/> DTs/Shakes	<input type="checkbox"/> Blackouts	<input type="checkbox"/> Binges	
<input type="checkbox"/> Overdoses	<input type="checkbox"/> Increased Tolerance (need more to get high)	<input type="checkbox"/> GI Bleeding	<input type="checkbox"/> Liver Disease	
<input type="checkbox"/> Sleep Problems	<input type="checkbox"/> Seizures	<input type="checkbox"/> Relationship Problems	<input type="checkbox"/> Left School	
<input type="checkbox"/> Lost Job	<input type="checkbox"/> DUIs	<input type="checkbox"/> Assaults	<input type="checkbox"/> Arrests	
<input type="checkbox"/> Incarcerations	<input type="checkbox"/> Homicide	<input type="checkbox"/> Other:		
<b>Longest Period of Sobriety?</b>			<b>How long ago?</b>	
<b>Triggers to use (list all that apply):</b>				
<b>Has client traded sex for drugs?</b> <input type="checkbox"/> No <input type="checkbox"/> Yes, explain:				
<b>Has client been tested for HIV?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>If yes, date of last test:</b>			<b>Results:</b>	
<b>Has client had any of the following problem gambling behaviors? Select all that apply:</b>				
<input type="checkbox"/> Gambled longer than planned	<input type="checkbox"/> Gambled until last dollar was gone			
<input type="checkbox"/> Lost sleep thinking of gambling	<input type="checkbox"/> Used income or savings to gamble while letting bills go unpaid			
<input type="checkbox"/> Borrowed money to gamble	<input type="checkbox"/> Made repeated, unsuccessful attempts to stop gambling			
<input type="checkbox"/> Been remorseful after gambling	<input type="checkbox"/> Broken the law or considered breaking the law to finance gambling			
<input type="checkbox"/> Other:	<input type="checkbox"/> Gambled to get money to meet financial obligations			
<b>Risk Taking/Impulsive Behavior (current/past) – select all that apply:</b>				
<input type="checkbox"/> Unprotected sex	<input type="checkbox"/> Shoplifting	<input type="checkbox"/> Reckless driving		
<input type="checkbox"/> Gang Involvement	<input type="checkbox"/> Drug Dealing	<input type="checkbox"/> Carrying/using weapon		
<input type="checkbox"/> Other:				



# CHILD/ADOLESCENT BIOPSYCHOSOCIAL ASSESSMENT

## Mental Status Exam

Category	Selections
<b>GENERAL OBSERVATIONS</b>	
<b>Appearance</b>	<input type="checkbox"/> Well groomed <input type="checkbox"/> Unkempt <input type="checkbox"/> Disheveled <input type="checkbox"/> Malodorous
<b>Build</b>	<input type="checkbox"/> Average <input type="checkbox"/> Thin <input type="checkbox"/> Overweight <input type="checkbox"/> Obese
<b>Demeanor</b>	<input type="checkbox"/> Cooperative <input type="checkbox"/> Hostile <input type="checkbox"/> Guarded <input type="checkbox"/> Withdrawn
	<input type="checkbox"/> Preoccupied <input type="checkbox"/> Demanding <input type="checkbox"/> Seductive
<b>Eye Contact</b>	<input type="checkbox"/> Average <input type="checkbox"/> Decreased <input type="checkbox"/> Increased
<b>Activity</b>	<input type="checkbox"/> Average <input type="checkbox"/> Decreased <input type="checkbox"/> Increased
<b>Speech</b>	<input type="checkbox"/> Clear <input type="checkbox"/> Slurred <input type="checkbox"/> Rapid <input type="checkbox"/> Slow
	<input type="checkbox"/> Pressured <input type="checkbox"/> Soft <input type="checkbox"/> Loud <input type="checkbox"/> Monotone
	Describe:
<b>THOUGHT CONTENT</b>	
<b>Delusions</b>	<input type="checkbox"/> None Reported <input type="checkbox"/> Grandiose <input type="checkbox"/> Persecutory <input type="checkbox"/> Somatic
	<input type="checkbox"/> Bizarre <input type="checkbox"/> Nihilist <input type="checkbox"/> Religious
	Describe:
<b>Other</b>	<input type="checkbox"/> None Reported <input type="checkbox"/> Poverty of Content <input type="checkbox"/> Obsessions <input type="checkbox"/> Compulsions
	<input type="checkbox"/> Phobias <input type="checkbox"/> Guilt <input type="checkbox"/> Anhedonia <input type="checkbox"/> Thought Insertion
	<input type="checkbox"/> Ideas of Reference <input type="checkbox"/> Thought Broadcasting
	Describe:
<b>Self Abuse</b>	<input type="checkbox"/> None Reported <input type="checkbox"/> Self Mutilization
	<input type="checkbox"/> Suicidal (assess lethality if present) <input type="checkbox"/> Intent <input type="checkbox"/> Plan
<b>Aggressive</b>	<input type="checkbox"/> None Reported <input type="checkbox"/> Aggressive (assess lethality of present)
	<input type="checkbox"/> Intent <input type="checkbox"/> Plan
<b>PERCEPTION</b>	
<b>Hallucinations</b>	<input type="checkbox"/> None Reported <input type="checkbox"/> Auditory <input type="checkbox"/> Visual
	<input type="checkbox"/> Olfactory <input type="checkbox"/> Gustatory <input type="checkbox"/> Tactile
	Describe:
<b>Other</b>	<input type="checkbox"/> None Reported <input type="checkbox"/> Illusions <input type="checkbox"/> Depersonalization <input type="checkbox"/> Derealization
<b>THOUGHT PROCESS</b>	
<input type="checkbox"/> Logical	<input type="checkbox"/> Goal Oriented <input type="checkbox"/> Circumstantial <input type="checkbox"/> Tangential
<input type="checkbox"/> Loose	<input type="checkbox"/> Rapid Thoughts <input type="checkbox"/> Incoherent <input type="checkbox"/> Concrete
<input type="checkbox"/> Blocked	<input type="checkbox"/> Flight of Ideas <input type="checkbox"/> Perserverative <input type="checkbox"/> Derailment
	Describe:
<b>MOOD</b>	
<input type="checkbox"/> Euthymic	<input type="checkbox"/> Depressed <input type="checkbox"/> Anxious
<input type="checkbox"/> Angry	<input type="checkbox"/> Euphoric <input type="checkbox"/> Irritable
<b>AFFECT</b>	
<input type="checkbox"/> Flat	<input type="checkbox"/> Inappropriate <input type="checkbox"/> Labile <input type="checkbox"/> Blunted
<input type="checkbox"/> Congruent with Mood	<input type="checkbox"/> Full <input type="checkbox"/> Constricted
<b>BEHAVIOR</b>	
<input type="checkbox"/> No behavior issues	<input type="checkbox"/> Assaultive <input type="checkbox"/> Resistant
<input type="checkbox"/> Aggressive	<input type="checkbox"/> Agitated <input type="checkbox"/> Hyperactive
<input type="checkbox"/> Restless	<input type="checkbox"/> Sleepy <input type="checkbox"/> Intrusive
<b>MOVEMENT</b>	
<input type="checkbox"/> Akathisia	<input type="checkbox"/> Dystonia <input type="checkbox"/> Tardive Dyskinesia <input type="checkbox"/> Tics
	Describe:
<b>COGNITION</b>	
<b>Impairment of:</b>	<input type="checkbox"/> None Reported <input type="checkbox"/> Orientation <input type="checkbox"/> Memory
	<input type="checkbox"/> Attention/Concentration <input type="checkbox"/> Ability to Abstract
	Describe:
<b>Intelligence Estimate</b>	<input type="checkbox"/> Mental Retardation <input type="checkbox"/> Borderline <input type="checkbox"/> Average <input type="checkbox"/> Above Average
<b>IMPULSE CONTROL</b>	<input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/> Absent
<b>INSIGHT</b>	<input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/> Absent
<b>JUDGMENT</b>	<input type="checkbox"/> Good <input type="checkbox"/> Poor <input type="checkbox"/> Absent

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<b>RISK ASSESSMENT</b>				
Risk to Self	<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High	<input type="checkbox"/> Chronic
Risk to Others	<input type="checkbox"/> Low	<input type="checkbox"/> Medium	<input type="checkbox"/> High	<input type="checkbox"/> Chronic
<b>Serious current risk of any of the following: (Immediate response needed)</b>				
Abuse or Family Violence <input type="checkbox"/> Yes <input type="checkbox"/> No		Abuse or Family Violence <input type="checkbox"/> Yes <input type="checkbox"/> No		
Psychotic or Severely Psychologically Disabled <input type="checkbox"/> Yes <input type="checkbox"/> No				
Is there a handgun in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No		Any other weapons? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Plan:				
Safety Plan Reviewed <input type="checkbox"/> Yes <input type="checkbox"/> No				

### Diagnoses and Interpretive Summary

<b>Biopsychosocial formulation</b>		
<b>DSM IV-TR Provisional Diagnoses</b>		
Axis I		
Axis II		
Axis III		
Axis IV		
Axis V		
<b>Treatment Acceptance/Resistance</b>		
Client accepts problem? <input type="checkbox"/> No <input type="checkbox"/> Yes Comment:		
Client recognizes need for treatment? <input type="checkbox"/> No <input type="checkbox"/> Yes Comment:		
Client minimizes or blames others? <input type="checkbox"/> No <input type="checkbox"/> Yes Comment:		
External motivation is primary? <input type="checkbox"/> No <input type="checkbox"/> Yes Comment:		
<b>Strengths/Resources</b> (enter score if present) <b>1 = Adequate, 2 = Above Average, 3 = Exceptional</b>		
Family Support	Social Support Systems	Relationship Stability
Intellectual/Cognitive Skills	Coping Skills & Resiliency	Parenting Skills
Socio-Economic Stability	Communication Skills	Insight & Sensitivity
Maturity & Judgment Skills	Motivation for Help	Other:
<b>Comments:</b>		
<b>Describe appropriateness &amp; level of need for the family's participation:</b>		

## CHILD/ADOLESCENT BIOPSYCHOSOCIAL ASSESSMENT

### Preliminary Treatment Plan & Referrals

Preliminary Biopsychosocial Treatment Plan			
<b>Biological:</b>  <b>Psychological:</b>  <b>Social/Environmental:</b>			
<b>Referrals</b>			
<input type="checkbox"/> Psychiatrist	<input type="checkbox"/> Psychologist	<input type="checkbox"/> Medical Provider	<input type="checkbox"/> Spiritual Counselor
<input type="checkbox"/> Benefits Coordinator	<input type="checkbox"/> Nutritionist	<input type="checkbox"/> Rehabilitation	<input type="checkbox"/> Vocational Counselor
<input type="checkbox"/> Social Worker	<input type="checkbox"/> Community Agency:		<input type="checkbox"/> Other:

### Physical Fitness (Optional)

<p><b>Physical Activity (please select one of the following based on activity level for the past month):</b></p> <p><input type="checkbox"/> Avoids walking or exertion, e.g. always uses elevator, drives whenever possible instead of walking.</p> <p><input type="checkbox"/> Walks for pleasure, routinely uses stairs, occasionally exercises sufficiently to cause heavy breathing or perspiration.</p> <p>Participates regularly in recreation or work requiring <b>modest physical activity</b> such as golf, horseback riding, calisthenics, gymnastics, table tennis, bowling, weight lifting, and yard work.</p> <p> <input type="checkbox"/> 10-60 minutes per week  <input type="checkbox"/> More than one hour per week         </p> <p>Participates regularly in <b>heavy physical exercise</b>, such as running, jogging, swimming, cycling, rowing, skipping rope, running in place or engaging in vigorous aerobic activity such as tennis, basketball or handball.</p> <p> <input type="checkbox"/> Runs less than a mile a week or engages in other exercise for less than 30 minutes per week  <input type="checkbox"/> Runs 1-5 miles per week or engages in other exercise for 30-60 minutes per week  <input type="checkbox"/> Runs 5-10 miles per week or engages in other exercise for 1-3 hours per week  <input type="checkbox"/> Runs more than 10 miles per week or engages in other exercise for more than 3 hours per week         </p>
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